TOWN OF NANTUCKET

COMMISSION ON DISABILITY

TOWN & COUNTY BUILDING
16 BROAD STREET
NANTUCKET. MA 02554
(508) 228-8085 (Voice and Fax)

APPLICATION FOR NANTUCKET DISABLED PARKING PLACARD

THIS SIDE OF THE APPLICATION MUST BE COMPLETED BY THE APPLICANT OR HIS/HER DESIGNEE

Mr./Mrs./Ms./Miss.

Last Name First Name MI

On Island Address

Mailing Address Date of Birth Telephone

Off Island Address City State Zip Code

ALL INFORMATION PROVIDED HEREIN SHALL BE HELD CONFIDENTIAL.

I am applying to the Nantucket Commission on Disability for a Nantucket Parking Permit for the Disabled to be used on the Island of Nantucket, MA.

I understand that the laws and regulations of the Commonwealth of Massachusetts and the Town of Nantucket shall govern the use of this permit. Failure to abide by these regulations shall be deemed just cause for revocation and surrender of the permit to the Chief of Police of Nantucket.

As part of this application, I am submitting the Physician's Statement on the reverse side for use by the Nantucket Commission on Disability in determining my eligibility for a permit. A permit will be issued only when a disability affects ambulatory mobility.

Use of this permit by anyone other than the applicant is cause for immediate revocation.

Signature of Applicant (or Designee) Date

Please mail this application to the Commission on Disability at the above address.

Should apersonal appearance before the Commission be necessary, you will be notified by mail of your date to appear. Your new permit may take up to a month to be issued. ***Should you need a temporary permit immediately, the Chief of P may issue you a ek permit. A Physician's Statement is required when applying to the Chief of Police.***

PHYSICIAN'S STATEMENT – PARKING PERMIT FOR DISABLED

Dear Healthcare Provider:
This is an application to allow your patient to display a local disabled placard. This will allow your patient to park in designated "handicapped" parking spaces designed to increase access for people with impaired mobility. The medical criteria you fill out below will enable the Commission on Disability to determine patient eligibility for the privilege of accessing select parking spaces.
Please be accurate and detailed as possible to ensure that the Commission on Disability may make a fair evaluation of your patient's application.

The disability is ☐ **Permanent** ☐ **Temporary**
If temporary: Anticipated length of disability _____
Please state clinical diagnosis and exact nature of impairment. (Mandatory answer)

_____

_____

_____

How does the disability affect patient's mobility? (Mandatory answer)

_____

_____

_____

Ambulatory aids used: _____

Please note which of the following disabilities is attributable to the applicant.

☐	Loss of, or loss of use of one or both feet	
☐	Replacement of Joint in lower extremity	H i p Knee A n k l e
☐	Complete ankylosis of major joint or lower extremity	Hip Knee Ankle
☐	Paralysis of lower extremity	H i p Knee A n k l e
☐	Arthritis of Joint in lower extremity	Hip Knee Ankle
☐	Chronic Lung Disease	
☐	Chronic Heart Disease	
☐	Other (Describe)	

_____

_____

_____

Name of Physician: (Please Print) _____
Mailing Address: _____
Office Phone: _____ **Signature:** _____

For Commission Use Only

Date Received _____
Permit Number _____
Permit Expires _____
Permit Renewal _____

COD Signatures _____

_____

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